STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ______ B. WING ______	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	2133 VADALABENE DRIVE MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 22	F 514		

Progress shows Ativan 0.5 was given on 3/29, the MAR shows it was given 11 times between 3/24/09 and 4/4/09 The PRN Notes show 2 times on 3/30 and 3/31. There were 2 different records for Ativan 0.5 q/3hrs PRN. One record had documentation showing 4 tablets were signed out between 3/30 and 4/1. The other record showed 10 tabs signed out between 3/31 and 4/5/09.

The PRN Medication Notes showed only 3 entries. 2 for Ativan given 3/30/09 and 3/31/09 and one for Haldol given 3/28/09. An interview with E2, Director of Nurses verified there was no other documentation showing why the PRN medications were given and what the outcome was.

F9999 FINAL OBSERVATIONS — F9999

LICENSURE VIOLATIONS

300.1210a)
300.1210b)6)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ____ B. WING ____	C **04/20/2009**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	**2133 VADALABENE DRIVE** **MARYVILLE, IL 62062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 23	F9999		

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on interview, record review and observation, the Facility failed to provide adequate supervision to prevent the elopement of one resident on the sample, R1. The Facility has identified 5 residents at high risk for elopement from the Facility. R1, who is cognitively impaired, left the Facility on 4/7/09 without the knowledge of the staff. R1 was found in Cardiac and Respiratory Arrest, and pronounced dead at the hospital emergency room.
.
Findings include:

Facility investigation, dated 4/7/09, states "(R1) is an 81 year old Caucasian male admitted to (Facility) on 3/24/09. His diagnoses include Dementia, Hypertension, heart disease, depressive disorder, anxiety, pain and failure to thrive. He had been receiving hospice services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ______ B. WING ______	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	**2133 VADALABENE DRIVE MARYVILLE, IL 62062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 24	F9999		

for a year prior to admission. (Family) and hospice personnel reported no wandering behaviors upon admission. On 4/7/09, (R1) was redirected to bed at 0230 by facility staff due to confusion and thought he was "going to a wedding." Staff visualized (R1) in his bed, dressed and asleep at 0245. Staff noted resident to be absent from his room when they checked at 0300. The window was open and the screen had been removed and placed internally next to his bed. A complete search of the building showed that the resident had left the facility. An outside search was initiated. The resident was located by a family member of staff approximately 8 blocks from the facility. Emergency Medical Services (EMS) arrived and transported resident to hospital emergency room where he was pronounced dead at 0412."

"Detail Incident Report" from local police states, "On Tuesday, 4/7/09, at 3:04 AM, I was advised of an elderly male that escaped out of his window at (Facility). Upon arrival to (Facility), I was advised by a worker that the male subject had been missing approximately 15-20 minutes. The worker stated that the male subject was wearing a red jacket and blue jeans with a pair of brown shoes. The worker stated the male subject escaped out of a window on the west side of the building but nobody saw which way he was traveling. The male subject is identified as (R1). I, along with a worker from (Facility) searched the perimeter of the building while another officer searched the surrounding area in his patrol vehicle. After a short search, advised to contact county and see if there was a K-9 unit available. Dispatch also advised (nearby city police) to see if they had an available unit to help with the search. I met with K-9 unit at (Facility) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ______ B. WING ______	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	2133 VADALABENE DRIVE MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 25	F9999		

showed him where (R1) had escaped from. The K-9 was tracking and after a short time the deputies were advised that there was a male subject matching (R1's) description laying near the side of the roadway. Officers arrived on the scene and observed that the male subject did not have a pulse. Officer started CPR. A short time later, medical staff arrived on the scene and took over CPR. Another male subject on the scene (Z3), had called police when he discovered (R1) laying next to the roadway. Z3 stated that his wife is a nurse at (Facility) and advised him (R1) was missing, so he came out to look for him. Z3 stated he was traveling north when he observed (R1) laying next to the roadway. Z3 said that he felt for a pulse but was not able to feel one and called the police."

Ambulance "Run Log" shows that EMS was initially contacted at 3:44 AM and arrived at the location where R1 was found at 3:53 AM. "(R1) primary complaint of Cardiac/Respiratory arrest. Observed condition - Cardiac Arrest. Intubated, following Advanced Cardiac Life Support protocol." The ambulance departed the location where R1 was found at 4:05 and arrived at the hospital emergency room at 4:07 AM.

Hospital emergency room (ER) records shows that R1 presented to the ER in a state of cardiac arrest, "Power of Attorney (POA), requests ceasing all resuscitation efforts upon arrival. Time of death - 4:12 AM." Emergency room "Physician Diagnoses" include: "1. Cardiac Arrest. 2. Pulmonary Arrest. 3. Hypothermia. 4. Do Not Resuscitate."

R1's Facility Admission Assessment, dated 3/25/09, shows "Cognitive Status - confused,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ______ B. WING ______	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	2133 VADALABENE DRIVE MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 26	F9999		

alert, responsive, short term memory problem, daily decision making problem. Steady gait. Wandering behaviors."

The following was noted in R1's Facility clinical record:

3/26/09, 7:30 PM - Resident noted to have screen off window of room and opened window. Resident noted to be on outside of facility standing with belongings. Resident assisted back into facility without hesitation. Window closed and screen replaced. Window knob (crank) removed to prevent opening again. Resident placed on 1 to 1's and given PRN (as needed) medication for anxiety. After resident was calm, resident placed on 15 minute checks. (Event)

3/28/09, 10:55 AM - Woke resident up this AM, very good spirits, anxious to go home, no attempts to exit facility.

8:25 PM - he has wanted to go home all evening. When I came out of (resident room), someone hollered that he went out of the front door. I took off and the 100 hall nurse met me at the front door. (R1) was walking towards the parked cars at the end of the parking lot. We got a hold of him and there were 6 staff outside. He would not move and said he has been told lies ever since he got here. The 100 hall nurse got him back in the building. (Progress Note)

9:26 PM - Called hospice and explained situation here. I told the nurse that resident out of control and needed something for him. Gave me an order for Haldol 1 milligram (mg) intramuscularly (IM), now. The order reads to give Haldol 1 mg orally or IM as needed every 6 hours" (Progress Note)

3/29/09, 11:29 AM - Resident anxious this morning, PRN Ativan given, resident more calm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ______ B. WING ______	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	2133 VADALABENE DRIVE MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 27 at this time, no attempts to exit facility. (Progress Note) 5:04 PM - Resident was put in here by daughter and does not want to stay. "He is going to go home - this is not his home." Resident got out of the the front door and at the end of parking lot when Certified Nurses Aides (CNA's) got him. Prior to this, I gave him .50 milligrams of Roxanol. Hospice and Doctor informed. (Event) 5:18 PM - Resident got out of the front door and at the end of the parking lot when CNA's got him. He was out of breath and running, and the girls were chasing him. Prior to this, I gave him .50 mg of Roxanol. (Progress Note) 7:02 PM - Hospice returned call with new order for Ativan 1 mg orally three times a day for agitation. I also called his daughter and she sent his granddaughter to visit with him. His Haldol IM had already been given and Roxanol. (Progress Note) 4/1/09, 4:31 AM - Resident was awake until 3:00 AM. In and out of room and trying to go to other residents room to use the bathroom. Very confused. (Progress Note) 7:45 AM - Resident was ambulating throughout the hallways as usual. Resident just fell backwards and collapsed, hitting the back of head on left side, and obtaining a skin tear to left elbow. Resident had both shoes on and floor was dry. Resident is under hospice care since prior to admission. He has had multiple medication changes to control behaviors and anxiety since admission. Hospice is aware and decreased Risperdal related to this fall. (Event) 9:10 AM - New order received per hospice to discontinue Risperdal 1 mg twice a day and Ativan 1 mg at night, and start Risperdal 0.5 mg every night. (Progress Note) 4/2/09, 11:15 AM - Roaming facility	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ______ B. WING ______	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	2133 VADALABENE DRIVE MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 28	F9999		

constantly. (Progress Note)

4/4/09, 2:44 AM - He was fine on evenings - someone with him and playing cards and walking all around the building. But tonight, he is in and out of the room. Wanting to pack the trailer and go home. He wants his truck. (Progress Note)

4/5/09, 5:15 PM - Alarm sounded on 400 hall. Resident noted going down 400 hall. Resident opened outside door and left facility. Resident in staff view at all times. Resident walked with staff around building and returned to facility without incident. (Progress Note)

10:35 PM - Resident noted attempting to climb out window. Resident assisted back to room and resident grabbed writer by the throat and stated "how do you like that?" Resident pushed writer against wall and pushed CNA making the CNA trip. Dr. notified and stated to give resident another 2 mg of Haldol intramuscularly. Family notified of behavior and needed to come out and sit with resident. (Progress Note)

4/7/09, 4:40 AM - At 3 AM, resident noted to be gone, window open screen out facility room........ (Progress Note)

On 4/9/09, at 2:25 PM, Z1, R1's physician, stated that he had only seen R1 one time, and that was on 4/1/09. Z1 said that during that visit, R1 "seemed pretty confused, but he'd been napping." Z1 said that since R1's death, he was told by a neighbors of R1 that R1 climbed out of the window several times and left without anyone's knowledge.

E6 and E7, CNA's, were both working with R1 the evening of 4/5/09. On 4/9/09, both stated that at approximately 10:30 PM, on 4/5/09, they entered R1's room and saw the window partially

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ______ B. WING ______	C **04/20/2009**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	**2133 VADALABENE DRIVE** **MARYVILLE, IL 62062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 29 open and R1 had one leg out of the window. E6 said that she pulled R1 back into the room. E6 said that R1 was confused and saying things that did not make sense. Both E6 and E7 confirmed that there was no crank on the window. R1 was able to open the window. They both confirmed that nothing else was done to secure the window after R1's second attempt to exit the Facility through the window. Z2, R1's POA, was interviewed by telephone on 4/13/09, at 9:20 AM. Z2 said that during the admission process at the Facility, she told E1 that R1 had Sundowners, Dementia and was restless at night. Z2 said that R1 was fine during the day but, once the sun went down, he became confused. Z2 said that the Facility hired someone on 4/3/09, to sit with R1 in the evenings. Z2 said that she knows that someone sat with R1 Sunday evening but, they left at approximately 9 or 10 PM. E8, LPN, who was the nurse on duty when R1 left the Facility on 4/7/09, was interviewed by telephone on 4/8/09 at approximately 9:30 AM. E8 said that at approximately 2:55 AM, she met two CNA's (E10 and E12) at the nurses station and they stated R1 was missing. The last time that E8 saw R1 was at 2:30 PM, "He was fully dressed and said that he was going to a wedding." E8 said that "I noted the window was open and the screen was out. I was surprised that the window was open as there was no crank on it to open it." E8 said that she called the police, E2 (Director of Nursing), R1's POA and then her husband - as she was upset. E8 and E5 CNA's walked the perimeter of the building. Meanwhile, E8's husband (Z3) started driving around looking for R1. At 3:45, Z3 called the	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ______ B. WING ______	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	2133 VADALABENE DRIVE MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 30 Facility and said that he found R1, approximately 9/10ths of a mile from the Facility, with no vital signs. E15, LPN, was interviewed on 4/8/09 at 1:35 PM. E15 said that R1 tried to leave the Facility on several occasions. E15 said that she was on duty the first time that R1 went out of the window on 3/26/09, and that's when the crank was removed. E15 said that R1 went to the front door a lot, wanting to leave. R1 went out of the 400 hall exit door before supper the evening of 4/5/09. E15 went out of the 300 Hall exit door and met him outside at the end of the building. E15 told him to come inside and play cards. E15 and the CNA's on duty took turns watching R1 all evening. At 10:15, on 4/5/09, he tried again to go out of 400 Hall exit door, "he said that he was going to a Shriner's meeting." R1 was wearing his red Shriner's jacket. "I told him that he missed the meeting and took him back to his room. He wouldn't let me put his jacket away. He started squeezing my fingers, and pushing into me with his body and pushed me into the door. He pinned me against the door, put his hands around my throat and started pushing on my carotid arteries with his thumbs. The CNA grabbed his shoulders and he slung her against the wall and pushed her." E15 said that she then paged R1's physician, E2, and R1's POA. E15 asked R1's POA to have someone come and sit with R1. Meanwhile, R1's physician gave a one time order for 2 mg of Haldol, given intramuscularly. E15 further stated "If I had realized the window could open after taking the handle off, I would have moved him to a courtyard room." Z3 was interviewed on 4/8/09 at 2:40 PM. Z3	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ______ B. WING ______	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	2133 VADALABENE DRIVE MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 31 said that on 4/7/09, a little after 3:00 PM, he was sleeping when his wife, E8 telephoned. E8 sounded frantic. Z3 could not go back to sleep so he decided to get into his car and drive around looking for R1. "I saw something on the ground out of the corner of my eye so did a U-turn and came back. He was lying on the sidewalk, his head turned toward the street, lying on his back with his arms out to his side at a 15 degree angle. There was not a mark on him, no blood. I checked his carotid pulse and thought I felt a very weak pulse. I felt for a heartbeat, felt for a breath. No response. His eyes were open and fixed. A lady pulled up about then and I told her to call 911. Police came almost immediately and started CPR." R1's room and window were examined on 4/8/09, at 3:00 PM, along with local Chief of Police (Z7), local police detective (Z6) and an investigator with the county coroner's office (Z5). R1's window screen was inside the room, resting on the wall next to the window. It was noted that the window in R1's room is two feet from the floor. There is an air conditioning/heating unit located directly under the window, which extends approximately 1 foot into the room and 1 foot beyond the exterior of the building. This provides a "step" underneath the window. It is a double window, with only the right side designed to open. The window is opened at the bottom with a crank located on the right side. There was no crank on the window however, the mechanism to open the window was present. There are two hinged latches in the center casement, each located 12 inches from the bottom and top of the window. The window is 55 1/2 inches high and 26 inches wide. The window opens outward, at the center. Z7 demonstrated that once the	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING ______ B. WING ______	C 04/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	**2133 VADALABENE DRIVE** **MARYVILLE, IL 62062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 32 latches were opened, the window easily opened by pushing on it. Z6 stated that the hinge at the bottom of the window was "sprung." It was also noted that the window could be opened by turning the mechanism at the bottom - no handle was required. On 4/8/09, at approximately 4:00 PM, Z3 took us (E1, Z7, Z6, Z5) to the area where R1 was found. R1 was found on a sidewalk located along a busy state highway approximately 9/10 ths of a mile from the Facility. The speed limit on this portion of the state highway is 45 miles per hour. Business's and open fields are located along the highway. The cement where R1 was found is slightly slanted, scattered with rocks and soil due to construction in the area. The local weather on 4/7/09 at 3:05 AM, shows that it was 37 degrees Fahrenheit, with 66% humidity, and 17 mile per hour winds from the west-northwest. This result in a temperature that "Felt Like" of 27 degrees Fahrenheit On 4/8/09, Z4, County Coroner, said that R1 was found wearing a pair of jeans, loafers, white socks, t-shirt and a dark red jacket. (A)	F9999		